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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called as required.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 4 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH M BANKS			2a. DATE OF DEATH MONTH DAY YEAR 3/27/85			2b. HOUR 3:00 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.				
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION DORCHESTER GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Not employed		12b. KIND OF BUSINESS OR INDUSTRY Housewife		
13a. STATE Maryland					13b. COUNTY Dorchester		13c. CITY OR TOWN Cooks Point		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry McGrath					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Frances Bailey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-16-0498		17. INFORMANT ADDRESS Kenneth O. Banks, Riesterstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a RENAL FAILURE, HYPERTENSION										
19a. DATE OF OPERATION /		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED /				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2) /						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) /		21f. LOCATION STREET CITY OR TOWN COUNTY STATE /						
22a. I certify that (a) (this hospital) attended the deceased from 19 80 to 3/27 19 85, that (b) (we) lost saw the deceased alive on 3/27 19 85, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) not view the body after death.										
22b. SIGNATURE Michael A. Moskewicz MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/27/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD				22e. ADDRESS 503 BYRN ST CAMBRIDGE MD. 21613						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-29-85		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS SHARAN FUNERAL HOME CAMBRIDGE, MD.				25a. DATE REC'D. BY REGISTRAR MAR 29 1985		25b. REGISTRAR'S SIGNATURE /				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 85 08463			
1- FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3 9 85			
1. DECEASED NAME FIRST MIDDLE LAST HERTHA N BOLDING				2b. HOUR 10:45 PM			
3. SEX F		4. RACE WH		5. DATE OF BIRTH MONTH DAY YEAR 8 23 03		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DOR. MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GLACOW NURSING Home		12a. USUAL OCCUPATION SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Talbot 13d. CITY OR TOWN Easton				13e. STREET ADDRESS / ZIP CODE Rt. 2 Box 304, 21601			
14. FATHER'S NAME FIRST MIDDLE LAST Julius Naber				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalie Siegert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-03-2122		17. INFORMANT ADDRESS Rt. 2 Box 296 Kathleen S. Wendt Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENILE DEMENTIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/9 1985 to 3/9 1985, that (I) (we) last saw the deceased alive on 3/9 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael A. Moskewicz MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD				22e. ADDRESS 503 134th ST CAMBRIDGE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-12-85		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN CORDOVA COUNTY TALBOT STATE MD.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 15 1985	

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 08464

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>VIOLA Lee Brerewood</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 5 85</i>		2b. HOUR <i>5:30 AM</i>
3 SEX <i>F</i>	4 RACE <i>CAUC</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 30 03</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>DORCHESTER</i> MD.	
10 CITY OR TOWN OF DEATH <i>CAMBRIDGE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DORCHESTER GEN</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>203 GLEN BURN AVE 21613</i>	
13a. STATE <i>MD</i>	13b. COUNTY <i>DORC</i>	13c. CITY OR TOWN <i>CAMB</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>LEVI B Phillips</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence Brannock</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>214-07-8069</i>		17 INFORMANT ADDRESS <i>JEFFREY WILLIAMSON 208-4244</i>	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Dehydration</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Senile dementia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Periphereal vascular disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>yrs</i> <i>yrs</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Marked tissue wasting, megacolonous right leg, Seizure disorder</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/2</i> , 19 <i>85</i> , to <i>3/5</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/5</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Hubert L. Fierly</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/5/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HUBERT L. FIERLY</i>		22e. ADDRESS <i>503 BYRN ST CAMBRIDGE MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>3/7/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Christ Churchyard</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cambridge Dor. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME</i>		ADDRESS <i>CAMBRIDGE MD.</i>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 must be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

MAR 13 1985

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1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELLA M. CARPENTER</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>1</b> YEAR <b>1985</b>		2b. HOUR <b>11:30 PM</b>
3. SEX <b>F</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>4</b> DAY <b>22</b> YEAR <b>02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>
13a. STATE <b>Delaware</b>		13b. COUNTY <b>Lewis</b>	13c. CITY OR TOWN <b>Lewes</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>E.</b> LAST <b>Blizzard</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Matilda</b> MIDDLE <b>Andre</b> LAST <b>Andre</b>		13e. STREET ADDRESS / ZIP CODE <b>428 Kings Highway 19958</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>221-32-0695</b>		17. INFORMANT ADDRESS <b>Thelma C. Williams, 410 Kings Hwy, Lewes De 19958</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ventricular Arrhythmia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b>P.M.</b> MONTH <b>19</b> DAY <b>19</b> YEAR <b>85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II) <b>N/A</b>	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT SCHOOL <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>2/26/85</b> to <b>3/1/85</b> and that (2) my opinion of death occurred on the date and hour and from the causes stated above; (3) I was (did) and not view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/1/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ann P. Wilke</b>		22e. ADDRESS <b>400 Maryland Ave. GE 21613</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>March 4, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Methodist Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Lewes</b>		COUNTY <b>Sussex</b>		STATE <b>Delaware</b>	
24. FUNERAL DIRECTOR NAME <b>Marvel-Short Funeral Home,</b>		ADDRESS <b>Delmar, Delaware</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1985</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP

DHMH 16 60M 7/84  
(MRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



8482

RECEIVED 10/10/00



MINI-FAIR





098193

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RUTH AMELIA CLARK.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 23 85</b> 7:54 PM		
3 SEX <b>female</b>	4 RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 2 1919</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS	7b. HOUR	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.		
11 CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Licensed Prac. Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>	13b. COUNTY <b>Dor.</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Rt 1 Box 75 A 21613</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Andrew William Simpson</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Della</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>147-12-6739</b>		17 INFORMANT ADDRESS <b>John L. Clark Item # 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC SARCOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>18 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>H. Edward Aylliffe</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/23/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Edward Aylliffe</b>		22e. ADDRESS <b>503 BYRN ST. CAMBRIDGE MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>3/27/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>E. NEW MARKET CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>E. NEW MARKET DOR. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 1 - 1985</b>		
ADDRESS <b>CAMBRIDGE MD.</b>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

03123

101103 No. 3

077116

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHNNY George CONAWAY, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3--6--85</b>		2b. HOUR <b>3 A M</b>		
1. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 27 82</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>2</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>618 Schoolhouse Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Cambridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>618 Schoolhouse Lane 21613</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHNNY G. CONAWAY, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE JUDLER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>215-06-1441</b>		17. INFORMANT <b>Josephine Sudler</b>		ADDRESS <b>618 Schoolhouse Lane Carb., Md.</b>		21613	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rhabdomyosarcoma - Terminal case</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Egbert Toro</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EGBERTO TORO, M.D.</b>		22e. ADDRESS <b>408 BYEN ST. - CAMBRIDGE, MD. 21613</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/9/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel AME Cemetary</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dorchester Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Boardley Funeral Home</b>		ADDRESS <b>812 Hubbard St. Cambridge, Md.</b>		25. DATE REC'D BY REGISTRAR <b>MAR 12 1985</b> REGISTRAR'S SIGNATURE <b>John Davidson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called immediately.

BP

20% COTTON 20% WOOL

WILSON & JONES



MAR 13 1982

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))

20M 4/82

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				5 0 8 4 6 8		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stacy Cromartie						2a. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR 3-5-1985			2b. HOUR A M A M		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 11-27-1919		6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.		7c. DATE PRONOUNCED DEAD Mar. 5 1985		2d. HOUR 3:52	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County			AM MD		
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE Md.						13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lacy Cromartie						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 214-16-9862		17. INFORMANT Jean Cromartie ADDRESS Cambridge, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolus. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Mace Jr.				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 3/6/85			
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.				ADDRESS Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-9-1985		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.			
24. FUNERAL DIRECTOR NAME Stewart Funeral Home				ADDRESS Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR MAR 15 1985			

17-1-51

17-1-51



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 4 6 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Mary Ellen Diemer</u> <u>Diemer MARY E</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3-1-85</u>		2b. HOUR <u>1:45 PM</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>10 12 25</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>59</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester</u> MD.	
10. CITY OR TOWN OF DEATH <u>Cambridge</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u> 13b. COUNTY <u>Dorchester</u> 13c. CITY OR TOWN <u>Cambridge</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>James G. Barnard</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Teresa Nehring</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>519-24-7492</u>		17. INFORMANT ADDRESS <u>Fred J. Diemer - Same as #13</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Cancer of Endometrium</u> DUE TO, OR AS A CONSEQUENCE OF <u>Stage IV.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/80</u> , 19 <u>80</u> , to <u>3/1/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/1/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>[Signature]</u>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dorchester General Hospital - Cambridge, MD</u>		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	23b. DATE <u>Mar 5 1985</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (CITY OR TOWN) <u>Southland</u> (COUNTY) <u>PG</u> (STATE) <u>MD</u>
24. FUNERAL DIRECTOR <u>Taylor Funeral Chapel Annapolis, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 4 1985</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 4 7 0

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Carlton L. Gillis</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 25 85</i>			2b. HOUR <i>11 31 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>Can.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 23 14</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>farmer</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Dor.</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Gillis</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bessie Cooper</i>		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Md. Dor. Cambridge</i>			
17. INFORMANT ADDRESS <i>Rt. 4 Box 218 Cambridge Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)							
22b. SIGNATURE <i>R. Norton Hall, M.D.</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/25/85</i>	
22d. THE PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>Dorchester Genl Hosp</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>3/28/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>E. NEW MARKET CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>E. NEW MARKET DOR. MD.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>THOMAS FUNERAL HOME CAMBRIDGE MD.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 29 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

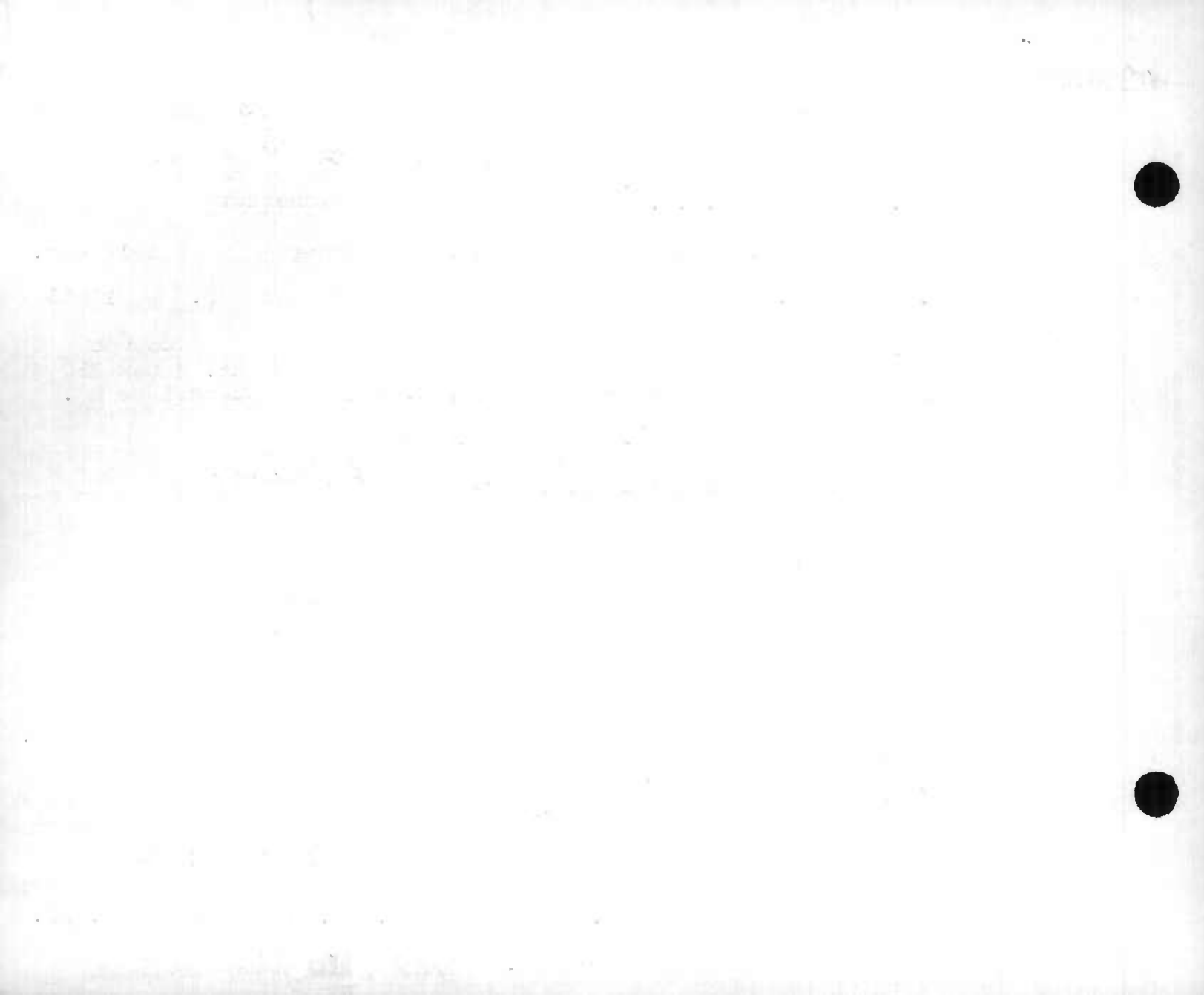
BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, a medical examination, or other traumatic event, the medical examiner must be notified at once.

093098



081007

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 4 7 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Oliver W. Gootee</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 14 85</b>		2b. HOUR <b>12:35 PM</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 28 12</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>laborer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>manufacturing</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Dor.</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>315 Maryland Ave. 21613</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Colfax Gootee</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Goulis Gore</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW 2</b>		16b. SOCIAL SECURITY NO. <b>213-12-5655</b>	17. INFORMANT ADDRESS <b>Virginia Gore Item # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Organic Brain Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2/24/85</b> , 19____, to <b>3/14/85</b> , 19____, that (I) (we) last saw the deceased alive on <b>3/14/85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Lawrence Mangano</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/14/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lawrence Mangano</b>		22e. ADDRESS <b>610 S. 2nd St. Cambridge, MD 21613</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b. DATE <b>3/16/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

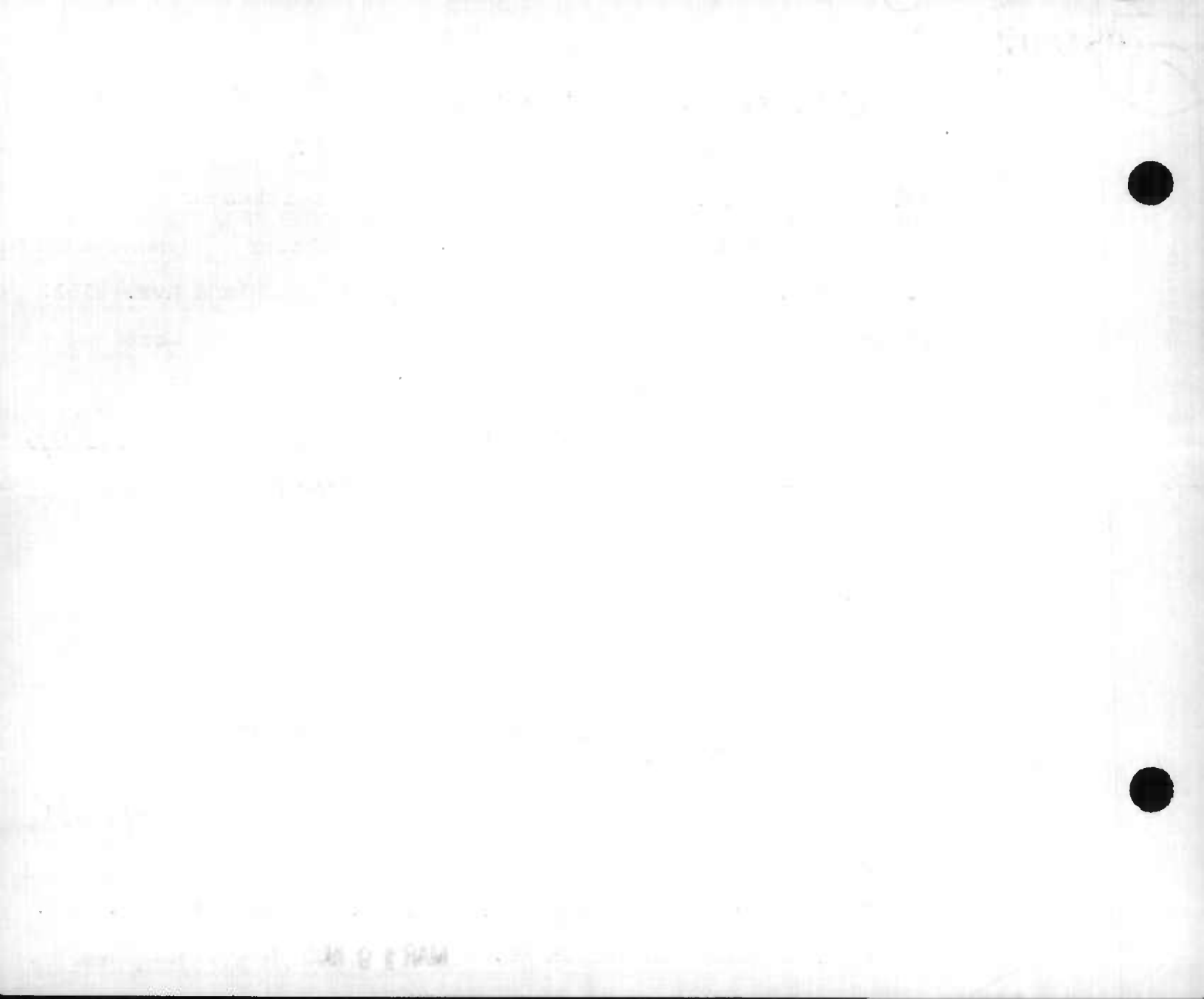
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, the death is due to injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP \_\_\_\_\_



098192

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08472	
1. DECEASED NAME (TYPE OR PRINT) <b>HARRY S. HALL</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 <b>5</b> HOUR <b>PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 15, 1895</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>90</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3-27 1985</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cabin Creek, Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hurlock</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Oak Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Oak Street 21643</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Lock Hall</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Medora Sherman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes WWI</b>						16b. SOCIAL SECURITY NO. <b>218-07-1086</b>		17. INFORMANT ADDRESS <b>Dorothy W. Lane, 319 Vassar Ave., Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burn shot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John Mace, Jr.</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER <b>DATE SIGNED 3/27/85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace, Jr. M.D.</b>				ADDRESS <b>604 Church St., Cambridge, Md. 21613</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Mar. 29, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Unity Washington Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hurlock, Dorchester, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Frampton-Hawkins Funeral Home, 216 N. Main St.</b>				ADDRESS <b>Federalsburg, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 1 1985</b>			
								25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 4 7 3

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> <sup>MIDDLE</sup> <sup>LAST</sup> Lena Bailey Hanna		2a. DATE OF DEATH MONTH DAY YEAR 3 - 23 - 85		2b. HOUR 2 55 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 12 1914	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS	
7c. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Dorchester		13c. CITY OR TOWN E. New Market	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert S. Bailey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Ryan		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Typist	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 315-07-0112		17. INFORMANT ADDRESS Rt. 1, Box 817 William S. Hanna III Hurlock, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterine cervix</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Papillary carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION 3-11-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Cervix		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1984</u> , 19 <u>84</u> , to <u>3-23</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>3-22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Michael J. Fadden</u>		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael J. Fadden, MD		22e. ADDRESS 302 Collins Avenue, Hurlock, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-23-85		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory	
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex, Delaware		25a. DATE REC'D. BY REGISTRAR MAR 29 1985	
25b. REGISTRAR'S SIGNATURE <u>John B. Fadden</u>					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

513-96-211

092083

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

March 11, 1985 8:00 PM

1. DECEASED NAME (TYPE OR PRINT) Sidney Rosco Higgins			2a. DATE OF DEATH MONTH DAY YEAR March 11, 1985			2b. HOUR 8:00 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 31, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.				
10. CITY OR TOWN OF DEATH Hurlock		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Webster Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lee Higgins					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caphronia Blake					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-01-3849		17. INFORMANT Ruth C. Higgins					
					18. ADDRESS 101 Webster Street Hurlock, MD 21643					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
<u>none</u>		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-85</u> , 19____, to <u>3-11</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jay Heeper</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-18-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jay Heeper</u>				22e. ADDRESS <u>306 Sandy Hill Rd Cambridge</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-85		23c. NAME OF CEMETERY OR CREMATORY EastNewMarketCem.		23d. LOCATION CITY OR TOWN COUNTY STATE E. New Market, Dorch., MD	
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, East New Market, MD				25a. DATE REC'D. BY REGISTRAR MAR 28 1985		25b. REGISTRAR'S SIGNATURE <u>Ruth Davidson-Rendell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. All data

2. All data

3. All data

4. All data

5. All data

6. All data

7. All data

8. All data

9. All data

10. All data

11. All data

12. All data

13. All data

14. All data

15. All data

16. All data

17. All data

18. All data

19. All data

20. All data

21. All data

22. All data

23. All data

24. All data

25. All data



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8508475	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) <b>ANNIE MAE Johns</b>				20. DATE OF DEATH MONTH DAY YEAR <b>3/1/85</b>	
3. SEX <b>F</b>		4. RACE <b>B</b>		21. HOUR <b>1:55</b> M	
5. DATE OF BIRTH MONTH DAY YEAR <b>01-06-05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Dorchester-Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homes</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 2, Box 211 21643</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Elbert</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Lou Adkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Renal failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Nephrosclerosis</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2-6-74</b> 19 <b>74</b> P.M.	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-6-74</b> 19 <b>74</b> to <b>March 1</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>March 1</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Barros</b> DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>3-1-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carlos F. Barros MD</b>		22e. ADDRESS <b>317 S. Main St. Hurlock Md 21643</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 5, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Johns Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Preston, Caroline, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>3-1-85</b>		23f. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
24. FUNERAL DIRECTOR NAME <b>Frampton-Hawkins Funeral Home</b>		ADDRESS <b>216 N. Main</b>		24a. DATE REC'D. BY REGISTRAR <b>3-1-85</b>	

BP

Frederick, Maryland

John Cemetery

Mar. 2, 1982

burial

Federal

Transcor-Landis Funeral Home, 210 N. Main St.

George A. Landis, 1910-1982

1910

3-1-82

2-6-82

Charles A. Landis, 1910-1982

1910-1982

1910-1982

Kathleen K. Landis, 1910-1982  
Washington, D.C.

Barbara Lou Landis

Barbara Lou Landis

Mar. 2, 1982

Domestic

Home

Domestic

077120

5/22/85 Item #13e L.J

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 8 4 7 6

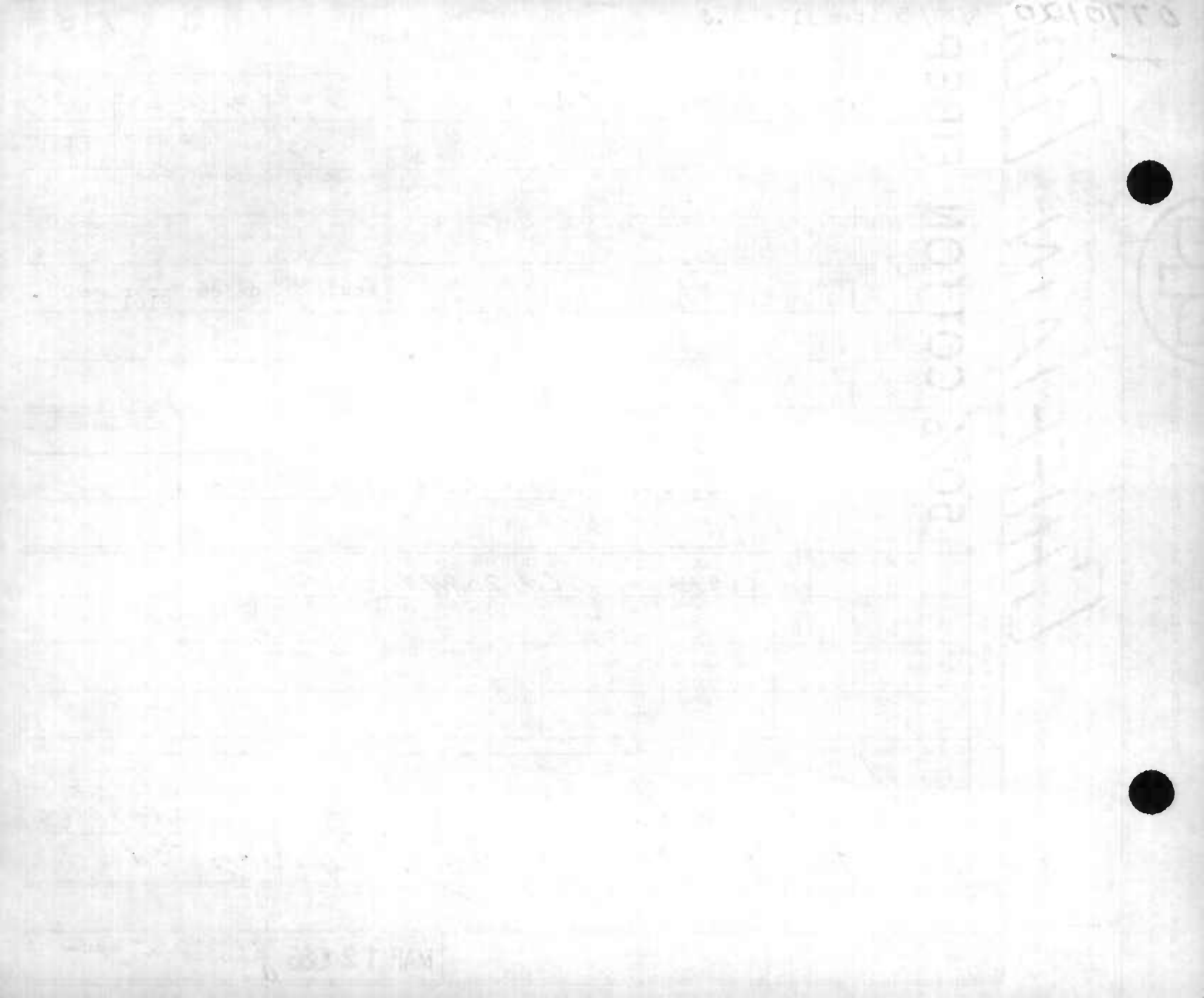
FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RUSSELL S. JONES</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>6</b> YEAR <b>85</b>			2b. HOUR <b>10 20 AM</b>					
3 SEX <b>Male</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>8</b> YEAR <b>32</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.					
10 CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Taylor's Island</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE <b>Route 2 Box 986 Cambridge Md. 21613</b>		
14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b>P.</b> LAST <b>Jones</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Bertha</b> MIDDLE <b>Mundy</b> LAST <b>Mundy</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-28-1575</b>			17 INFORMANT <b>Oneda Jones</b>			ADDRESS <b>Rt. 2 #300 Cambridge, Md. 21613</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE UNCONTROLLED HYPERTENSION</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>SEVERE SCHIZOPHRENIA</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (I) did not see the body after death.											
22b. SIGNATURE <b>R. Norton Hall</b>						DEGREE		22c. DATE SIGNED <b>3/6/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. NORTON HALL, MD.</b>						22e. ADDRESS <b>264 Cambridge Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/11/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lane U M Cemetary</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Taylor's Island Dorchester Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Boardley Funeral Home</b>						ADDRESS <b>812 Hubbard St. Cambridge, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) <b>HELEN M MOWBRAY</b>					2a DATE OF DEATH MONTH DAY YEAR <b>3 27 85</b> 2b HOUR <b>9 15</b> P.M.				
3 SEX <b>F</b>		4 RACE <b>CAUC</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12 29 04</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.			
10 CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>323 WEST END AVE</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MD</b>		13b COUNTY <b>DORCHESTER</b>		13c CITY OR TOWN <b>CAMBRIDGE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>323 WEST END 21613</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN HAVLICK</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATIE NOSSICK</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b SOCIAL SECURITY NO. <b>214-34-3400</b>		17 INFORMANT ADDRESS <b>JOHN MOWBRAY 10 METROMY WEATHER DR</b>		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YEAR</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>DIABETES MELLITUS, ASCVD</b>									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (A) (this hospital) attended the deceased from <b>3</b> 19 <b>84</b> , to <b>3/27</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> 19 <b>85</b> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (Do not) view the body after death.									
22b. SIGNATURE <b>Hubert L. Fleury</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/27/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUBERT L. FLEURY MD</b>					22e. ADDRESS <b>503 BYRON ST CAMB. MD 21613</b>				
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>3/30/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OUR LADY GOOD COUNSEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SECRETARY DOR. MD.</b>		
24 FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b> ADDRESS <b>CAMBRIDGE MD.</b>					APPROPRIATE REC'D. BY REGISTRAR <b>APR 1 1985</b> REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>				

BP

098175



GREEN NO. 10101

MAILED

Handwritten notes and stamps, including a large '1' and various illegible markings.

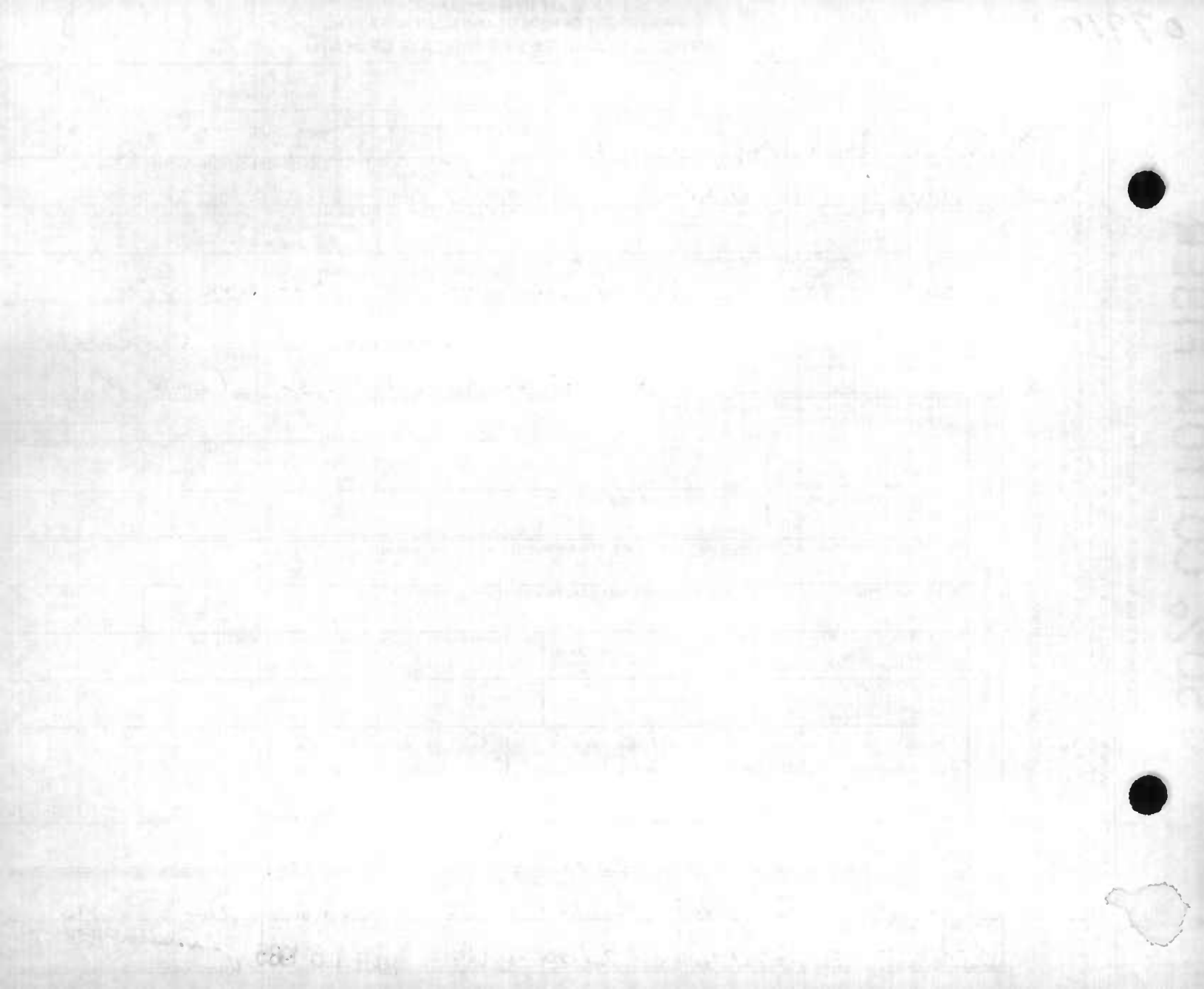
079102

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DETAILS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08478	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sylvia Pinder										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 26 1985	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb 2 1957		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 26 1985		2d. HOUR 4PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Cambridge				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laboree										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Dor		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 522 Pine St. 21613			
14. FATHER'S NAME FIRST MIDDLE LAST Rudell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Canaway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 218-48-8526		17. INFORMANT Rudell Major				ADDRESS Camb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Shotgun wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 26 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) wooded area		21f. LOCATION STREET CITY OR TOWN COUNTY STATE rear of 506 High St., Cambridge, Dorcheshter, Md					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Ann M. Dixon				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 2/27/85			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St. Balto., Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/2/1985		23c. NAME OF CEMETERY OR CREMATORY Bethel Ceme				23d. LOCATION CITY OR TOWN COUNTY STATE Camb. Dor. Md.	
24. FUNERAL DIRECTOR NAME Stewart Funnell						ADDRESS Salisbury Md.		25a. DATE REC'D. BY REGISTRAR MAR 15 1985		25b. REGISTRAR'S SIGNATURE J. Davidson	

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



098200

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8508479

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>IDA RAE</b>		2a. DATE OF DEATH MONTH <b>3</b> DAY <b>25</b> YEAR <b>85</b>		2b. HOUR <b>7<sup>15</sup> A.M.</b>
3. SEX <b>F</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>02</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.
7a. BIRTHPLACE STATE OR FOREIGN <b>Massachusetts</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester Co.</b> MD.
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b> COUNTY <b>Dor</b> CITY OR TOWN <b>CGE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>701 Race St 21613</b>	
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Horton</b> LAST <b>N.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b>Prover</b> LAST <b>Prover</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>033-14-3208</b>		17. INFORMANT <b>Dr. Donald Rae</b>
		ADDRESS <b>Route #1, Box 115 E. New Market, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive failure,</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis, fungemia.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Perforated Viscus, peritonitis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3db</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Temporal Arteritis, Ulcer</b>				
19a. DATE OF OPERATION <b>3.17.85</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated Viscus</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N/A 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) <b>N/A</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT HOME <input type="checkbox"/> <b>N/A</b>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>	21f. LOCATION STREET <b>N/A</b> CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>3.24</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Ann R. Wink</b>		DEGREE	22c. DATE SIGNED <b>3.25.85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ann R. Wink</b>		22e. ADDRESS <b>700 Maryland Ave. CGE 21613</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	23b. DATE <b>3/25/85</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 28 1985</b>		
		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SHE

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1- STATE REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie Rae Riggins</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3</b> DAY <b>23</b> YEAR <b>1985</b>			2b. HOUR <b>P.</b>		
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>Aug</b> DAY <b>2</b> YEAR <b>1923</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>61</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD MONTH <b>Mar.</b> DAY <b>23</b> YEAR <b>1985</b>		2d. HOUR <b>3PM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.		
10. CITY OR TOWN OF DEATH <b>Hurlock</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>companion for elderly</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>Hurlock</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>Oak Street 21643</b>	
14. FATHER'S NAME FIRST <b>Arch</b> MIDDLE <b></b> LAST <b>Riggins</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ina</b> MIDDLE <b></b> LAST <b>Long</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		
16b. SOCIAL SECURITY NO. <b>215-20-1297</b>			17. INFORMANT ADDRESS <b>Mrs Delsie Bezuchamp, Princess Anne Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few Mins.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John Mace Jr.</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>3/25/85</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John Mace Jr. M.D.</b>			ADDRESS <b>Cambridge, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>3/26/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beechwood Cem.</b>		23d. LOCATION CITY OR TOWN <b>Princess Anne</b> COUNTY <b>Somerset</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hinman Funeral Home Princess Anne Md</b>			ADDRESS <b></b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 29 1985</b>		
						25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>		

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M7/77

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to certify the death.

079067  
5STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8 4 8 1

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Barbara Theresa Shinek</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>02 - 27 - 85</i>		2b. HOUR <i>8:05 P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>6 20 98</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i>	7. UNDER 1 YEAR MONTHS DAYS <i>8 05</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Cambridge</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MD</i> 13c. COUNTY <i>Dorchester</i> 13d. CITY OR TOWN <i>E. New Market</i>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13f. STREET ADDRESS / ZIP CODE <i>Cedar Grove Road/21631</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Navratil</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Barbara Nekola</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-01-8616</i>		17. INFORMANT <i>Theresa Shinek</i> ADDRESS <i>Box 126A East New Market, MD</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Cardio-pulmonary arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Respiratory distress*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*seconds**days*PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *0*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>2-27-85</i> to <i>2-27-85</i> , that (I) (we) last saw the deceased alive on <i>2-27-85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>C. L. Galun, MD</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Christine L. Galun, MD</i>	22e. ADDRESS <i>Dorchester General Hosp, Cambr, Md.</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>3-2-85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Our Lady of Good Counsel</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Secretary, Dorch., MD</i>
24. FUNERAL DIRECTOR <i>Zeller Funeral Home, East New Market, MD</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 15 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Caroline J. Gendall</i>

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

085082

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>GEORGE ALVSTER SMITH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 15, 1985</b>		2b. HOUR P.M. <b>1:19 P.</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 29, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kingston, Jamaica</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Jamaica</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cambridge</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor - Coldwater Seafood</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Hurlock</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mortimer Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily Wallen</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-84-5529</b>	
17. INFORMANT ADDRESS <b>Elizabeth Smith, Box 231, Hurlock, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden cardiac Death</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Status Post CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> , 19 <u>84</u> , to <u>12-18</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>12-18</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael Hellen</i> MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 23, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Federalsburg, Caroline, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>FRAMPTON-HAWKINS</b>		ADDRESS <b>BOX 43</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8 4 8 3

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Carrie</u> MIDDLE: <u>Hurst</u> LAST: <u>Webster</u> <i>CARRIE H WEBSTER</i>			2a. DATE OF DEATH MONTH: <u>3</u> DAY: <u>3</u> YEAR: <u>85</u>			2b. HOUR <u>4.30</u> M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH: <u>5</u> DAY: <u>8</u> YEAR: <u>01</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester County</u> MD.					
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Dorchester</u>		13c. CITY OR TOWN <u>Secretary</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>Main Street/21664</u>		
14. FATHER'S NAME FIRST: <u>Charles</u> MIDDLE: LAST: <u>Hurst</u>			15. MOTHER'S MAIDEN NAME FIRST: <u>Amanda</u> MIDDLE: LAST: <u>Dukes</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO <u>220-32-0713</u>		
17. INFORMANT <u>Raymond Webster</u>			18. ADDRESS <u>419 Maryland Ave.</u>			19. CITY OR TOWN <u>Cambridge, MD</u>			20. STATE <u>21613</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF <u>Urinary T. Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Hyponatremia TIA</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. Tanman</i>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-3-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. Tanman</u>						22e. ADDRESS <u>17 Franklin Street, Cambridge, MD</u>					
23a. BURIAL, CREMATION, REMOVAL SPECIFY: <u>Burial</u>			23b. DATE <u>3-6-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EastNewMarketCem.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>E. New Market, Dorch., MD</u>			
24. FUNERAL DIRECTOR NAME: <u>Zeller Funeral Home, East New Market, MD</u> ADDRESS: _____						25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		25b. REGISTRAR'S SIGNATURE <i>William H. Haddell</i>			

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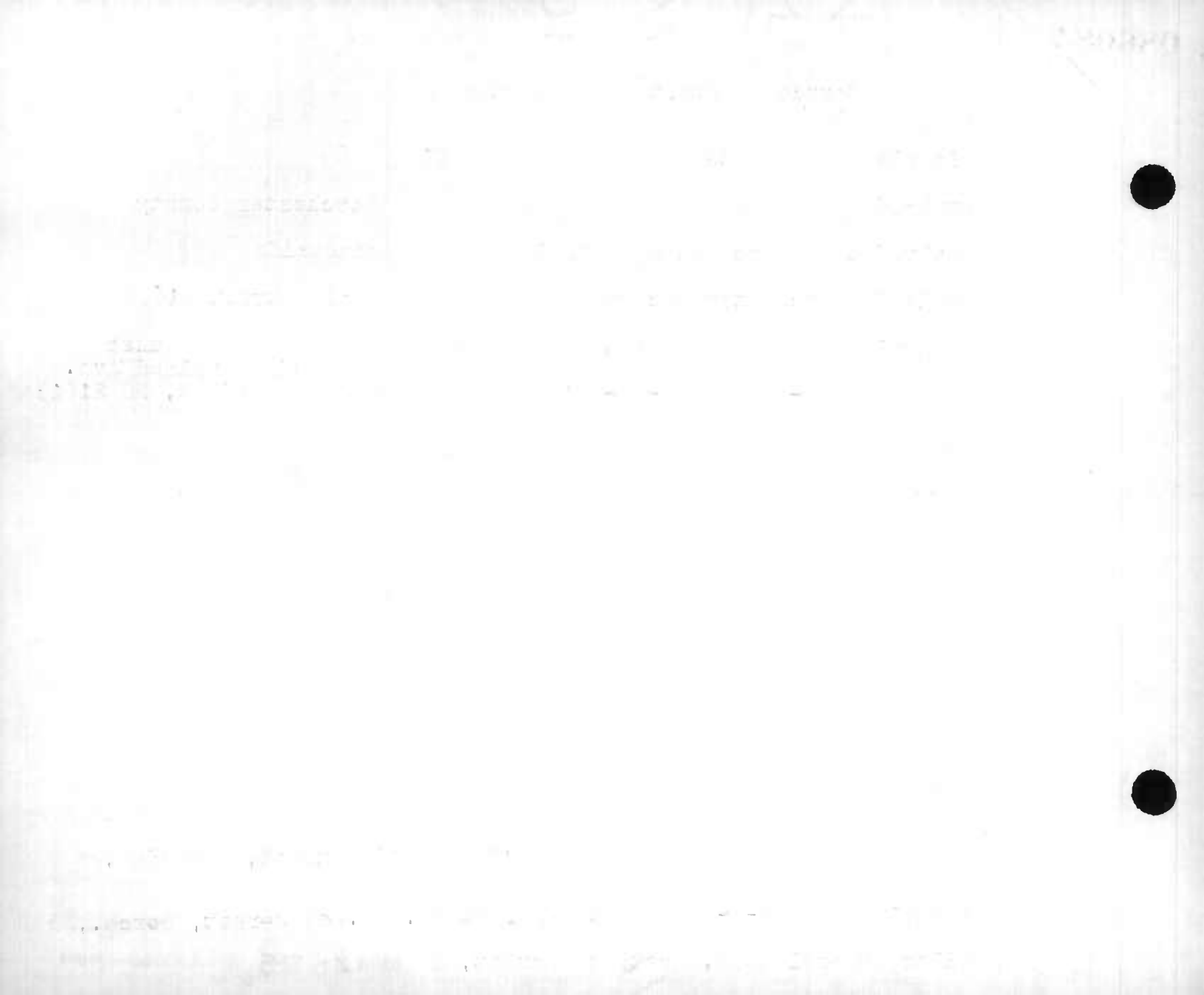
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

032088

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**ANNA N. Wheatley**

2a. DATE OF DEATH MONTH DAY YEAR  
**3-21-85**

2b. HOUR  
**7:56 AM**

3. SEX  
**FEMALE**

4. RACE  
**White**

5. DATE OF BIRTH MONTH DAY YEAR  
**04 23 04**

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.  
**80**

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Maryland**

7b. CITIZEN OF WHAT COUNTRY?  
**USA**

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**DOR.** MD.

10. CITY OR TOWN OF DEATH  
**Cambridge**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Cambridge House Nursing Home**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Housewife**

12b. KIND OF BUSINESS OR INDUSTRY  
**-**

13a. STATE  
**MD**

13b. COUNTY  
**Dorchester**

13c. CITY OR TOWN  
**Hurlock**

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS  
**Taylor Avenue/21643**

14. FATHER'S NAME FIRST MIDDLE LAST  
**John Nossick**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Anna Whiteley**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
**No**

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  
**216-10-2854**

17. INFORMANT ADDRESS  
**Eleanor D'Adamo East New Market, MD**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Respiratory Arrest**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **COMA 2° to MASSIVE CVA**  
DUE TO, OR AS A CONSEQUENCE OF (c) **atherosclerotic vascular disease**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **1-22** 19 **84** to **3-21** 19 **85**, that (I) (we) lost saw the deceased alive on **3-5** 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE  
**Michael J. Fadden MD**

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS  
**Michael J. Fadden 302 Collins Hurlock Md 21643**

22e. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

23b. DATE  
**3-23-85**

23c. NAME OF CEMETERY OR CREMATORY  
**Our Lady of Good Counsel, Secretary, Dorch., MD**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**Dorchester MD**

24. FUNERAL DIRECTOR  
**Zeller Funeral Home, East New Market, MD**

25a. DATE REC'D BY REGISTRAR  
**MAR 28 1985**

25b. REGISTRAR'S SIGNATURE  
**J. A. Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Every day be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO

08485

1. DECEASED NAME (TYPE OR PRINT) <b>HERBERT WILSON WHITE</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>17</b> YEAR <b>85</b>			2b. HOUR <b>7:10 AM</b>								
3. SEX <b>M</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>27</b> YEAR <b>03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b> MD.								
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DORCHESTER GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>auto. mechanic</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Dorchester</b>			13c. CITY OR TOWN <b>Cambridge</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>Rt. 2, Box 108 D 21613</b>		
14. FATHER'S NAME FIRST <b>PARKER</b> MIDDLE <b>WILSON</b> LAST <b>WHITE</b>			15. MOTHER'S MAIDEN NAME <b>ELIZABETH MARTITA BAKER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 240-07-5561</b>			17. INFORMANT <b>wife</b> ADDRESS <b>White Rt. 2 Box 108 D</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>YRS.</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>MARILED ESOPHAGEAL REFLUX, DIABETES</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <b>3/17</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Hubert L. Fierly</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/17/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUBERT L. FIERLY</b>						22e. ADDRESS <b>503 BYRN ST</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>3/19/85</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Raleigh Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Raleigh Wake N. Carolina</b>					
24. FUNERAL DIRECTOR NAME <b>Curran Funeral Home, 308 High</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 20 1985</b>			25b. REGISTRAR'S SIGNATURE <b>W. Davidson-Randall</b>								

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